The following questions have been posed by parents during the Powerful Parents meetings that occurred throughout the state this fall. Please see the answers below. All of the meetings included information about the following:

Case Management
Transportation
Housemates/OBA
Recap of new DDRS Medicaid Waivers:
Family Supports Waiver (FSW)
Community Integration and Habilitation (CIH)

GENERAL

Where do I find the DDRS Waiver Manual?
The 2012 DDRS Waiver Manual can be found on the DDRS website at http://www.in.gov/fssa/ddrs/4312.htm.

Is information in the 2012 DDRS Waiver Manual "live", meaning is it effective now, as it sits, in print?
The DDRS Waiver Manual reflects waiver changes that have been approved by the Centers for Medicare and Medicaid Services (CMS), which became effective September 1, 2012.

Does information in the 2012 DDRS Waiver Manual have to go into any kind of Rule, including Emergency Rule, to be activated?
The information in the Waiver Manual has been compiled as resource for families, individuals, and providers. Much of the information was pulled from the federally approved FSW and CIH Waiver documents. (Information regarding Hoosier Healthwise, Care Select, etc., was not pulled from the federally approved FSW or CIH Waiver documents.)

How are Rules promulgated, and is information in the 2012 DDRS Waiver Manual something that must be promulgated to be effective?
Rules are promulgated in accordance with the Administrative Rules Drafting Manual, found at http://www.in.gov/legislative/pdf/IACDrftMan.PDF. As stated above, the information regarding the FSW and CIH Waivers must be federally approved. The Centers for Medicare and Medicaid Services (CMS) is the federal entity that must review and approve all Waiver proposals and amendments for each state.

Where can I find the Emergency Rule?
No emergency rule exists for the 2012 DDRS Waiver Manual. In general, all rules are published in the Indiana Register.

Could we have an update on the move to match provider agencies having special expertise with clients who need their services?
DDRS is currently working on this and will post it as soon as it is finalized.

Are environmental or vehicle modifications offered on the Family Supports Waiver.
No, not at this time. The Family Supports Waiver is the same waiver as the Supports Service Waiver, though two new services – Participant Assistance and Care, as well as Case Management – have been added, and the name changed. Environmental or Vehicular modifications were never part of the Support Services Waiver.

If someone is currently on the Aged and Disabled (A&D) Waiver, will he/she be forced to take the FSW if targeted, or can they decline the FSW and remain on the A&D?
Please contact your A&D case manager for further information.

Parents of children on the A&D Waiver are being told that they should keep their children on the A&D Waiver until the CIH Waiver is available. Is this true?
The CIH Waiver is only accessible by needs-based, emergency criteria. Unless an individual meets these criteria, the CIH Waiver will not be available. Criteria for this waiver can be found at http://www.in.gov/fssa/ddrs/4245.htm.

Families have been told that if they don't meet the robust eligibility requirements for the A&D waiver, they should apply for the DD Waiver. Since the DD waiver is now the CIH Waiver – which is needs-based and only accessible by emergency criteria, what should these families do?
If someone does not meet eligibility for the A&D Waiver and is interested in finding out if he/she is eligible for services through the Division of Disability and Rehabilitative Services, he/she should contact his/her local Bureau of Developmental Disabilities Services (BDDS) office.

To locate this office, please call 1-800-545-7763 or find your local office at http://www.in.gov/fssa/ddrs/4088.htm.

Does OBRA still exist to get an individual community services when he/she lives in a nursing home?
Yes.

What is the most recent targeting date?
The most recent targeting for the Family Supports Waiver included individuals with an application date of July 1, 1999.

Will you talk about the number of slots available on each Waiver? Will you be targeting for the CIH waiver?

The Family Supports Waiver, for which the waiver year ends on March 31, 2013, has 1885 slots available.

There are 796 slots available for the CIH Waiver, for which the waiver year ends September 30, 2013. As indicated before, the CIH waiver is only accessible by needs-based, priority criteria; there is no targeting for this waiver. For additional information, please refer to the handout, "Family Support Waiver (FSW) and Community Integration and Habilitation (CIH), under Eligibility Criteria, or at http://www.in.gov/fssa/ddrs/3355.htm#Powerful_Parents.

SERVICES

Is there a specific requirement for the number of staff in ratio to individuals under Respite?

The State does not mandate specific staffing ratios for Respite services; Respite services are allowable as individual or group. Respite care must be reflected in the Individualized Support Plan. For more information, please see the 2012 Waiver Manual, section 10.25 at http://www.in.gov/fssa/files/DDRS_Waiver_Manual_Fall_2012.pdf.

Can a parent, who is not the legal guardian of his/her child, provide Structured Family Caregiving (previously known as Adult Foster Care)?

Yes. For more information, please see the 2012 Waiver Manual, section 10.33, at http://www.in.gov/fssa/files/DDRS_Waiver_Manual_Fall_2012.pdf.

CASE MANAGEMENT

We have seen a brief memo naming four case management companies available to us as of September 1, 2012. How can we, as lay individuals (parents & guardians), obtain *credible information* about the new Company Manager relative to:

a) **their professional training including the colleges attended with a degree in what area of study and corresponding dates of completion,**
b) **their disability related experience naming the position held and where & for how long in that specific position, and**
c) **what specific standards they have committed to adhere to in the employment of case managers to work with our disabled children.**

Also, we ask who will be the DDRS staff liaison that will provide oversight to the Case Management supervisory staff effective 9/1/12?
If the individual already has waiver services, you may contact your Case Management company (CM) for a pick list, or, if not, you may contact your local BDDS office for a pick list. We, BDDS, must remain completely unbiased, but have standards in place so that only the highest quality companies are approved for CM.

- *Please see DDRS Announcement: Case Management Announcement 8.24.12.pdf - http://www.in.gov/fssa/files/Case_Management_Announcement_8.24.12.pdf*
- *You may ask the CM company to provide professional training information*
- *You may access the CM company provider requirements at: http://www.in.gov/fssa/ddrs/2644.htm, in which Case Manager duties to the consumer will not/have not changed*
- *A DDRS staff liaison will provide oversight to the CM companies*
- *BQIS will monitor these services*
    - *To report any complaints:*
        1. *Call toll free Complaint Hotline: 800-545-7763 or*
        2. *E-mail bqis.help@fssa.in.gov*

Are all four of the case management companies able to provide services in all counties of Indiana?
All providers are approved state wide; however, some case management companies have voluntarily opted out of some counties. If a case management company has voluntarily opted out of a county, it will not show up on that county's pick list.

How do we find out which case management companies provide services in our area?
Contact your current case manager or local BDDS office to obtain a case management pick list for your area.

What do I do if the case management company that I'd like to use doesn't indicate on its website that it serves my county?
You may call the case management company and ask them if they are interested in serving your county or if they plan on serving your county.

What are the timelines in which a case management company has to respond to a family to indicate if it can provide case management services to an individual if he/she lives outside of the company's listed service area?
Once all assessments have been made, applicants under the age of 18 and their legal guardians are given a pick list by BDDS containing providers of Case Management services that are approved by DDRS to provide service in the applicant's county of residency. Due to the disregard of parental income for minors receiving waiver services, proof of an approved Plan of Care/Cost Comparison Budget (CCB) may be required before some minors can obtain Medicaid eligibility, and the selection of a Case Manager is required before the CCB can be created. For adults, generation of the Case Management agency pick list by BDDS and selection of a Case Management agency will not occur until after all eligibility criteria are met, including establishment of Medicaid eligibility in a waiver-compatible Aid Category. Thereafter, the applicant/guardian (if applicable) completes the service planning process, chooses a service provider(s), and the Case Manager submits a CCB for waiver service.

The only timelines associated with Case Management are the following, taken from the DDRS Waiver Manual 2012, http://www.in.gov/fssa/files/DDRS_Waiver_Manual_Fall_2012.pdf:

Once the pick list is provided by BDDS, the individual/guardian has:
- *five (5) days to interview and choose a permanent case manager*
- *14 days to interview and choose, at minimum, one provider*

Under the new Family Supports Waiver (FSW), the cap has increased from $13,500 to $16,250. Does case management receive all of the $2,750 increase?
No, the case management cost is $125 per person per month, for anyone in waiver services (FSW and CIH). The total per year is $1500 and is paid through the individual's annual budget. The remaining $14,750 can be spent on other services as noted from the individualized support plan.

Does every Case Management company take out the same amount of pay for each individual?
Yes, each case management company receives $125 monthly, which is paid out of the individual's annual budget allocation.

OBA/ALGOS

On the policy document for "Changes to the OBA for Plan Year 3," the following is listed:

Algo Level	0	1	2	3	4	5 & 6
RHS Hours/ day	.2	2	3	5	7	8
Total	$1,696.52	$16,956.20	$25,447.80	$42,413.00	$59,378.20	$56,998.40

Are there really more hours allocated for an Algo 5 with less funding, or is that a typo?
*There is a typo in Algo 4: it should be **$49,873.60**. The change is now reflected on the document that exists online.*

I don't understand what an Algo level is: what is it, how are the levels determined, and how does a budget have anything to do with an Algo level?
The nationally recognized Inventory for Client and Agency Planning (ICAP) was selected to be the primary tool for individual assessment.

The ICAP assessment determines an individual's level of functioning for Broad Independence and General Maladaptive Factors. The ICAP Addendum, commonly referred to as the Behavior and Health Factors, determines an individual's level of functioning on behavior and health factors.

These two assessments determine an individual's overall Algo level which can range from 0-6. Algos 0 & 6 are considered to be the outliers representing those who are the lowest and the highest on both ends of the functioning spectrum. Upon review, the State may manually adjust the designation of an individual from an Algo 5 to an Algo 6. While this Individual will continue receiving the Algo 5 budget, the Algo 6 designation indicates a need for additional oversight of the individual.

The Objective Based Allocation (OBA) is the method used by the state to determine the level of supports an individual needs in order to live in a community setting while receiving services under the Community Integration and Habilitation Waiver. The OBA is determined by combining the Overall Algo (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement. For more information on the OBA please refer to training modules (http://www.in.gov/fssa/ddrs/4194.htm) that were offered as guidance on the implementation of this new method.

	ALGO Level					
Individual RHS Daily Hours	**0**	**1**	**2**	**3**	**4**	**5 & 6**
	Low	**Basic**	**Regular**	**Moderate**	**High**	**Intensive & High Intensive**
Living with Family	0.2	2	3	5	7	8
Living Alone	0.2	2.6	6	9	11.7	21
Living with One Housemate	0.2	2.6	5.3	7.8	11	12
Living with Two Housemates	0.2	2.6	4.6	7.8	10.1	11
Living with Three Housemates	0.2	2.4	4.3	7.3	9.4	10
BMAN Reserve (Annual hrs)	0	0	36	72	108	144
Structured Family Caregiving ($/day)	51.87	51.87	75.87	102.87	102.87	102.87
Day Service Reserve ($/Yr)						
Not Attending School	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 18,000.00
Attending School or under 19yrs.	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00

Note that the OBA methodology is not used with the already capped Family Supports Waiver.

Note that only individuals designated by the State as inappropriate for shared staffing or housemates will receive a "Living Alone" budget. All others will receive the base allocation of "Living with Two Housemates."

Further information can be found in the 2012 DDRS Waiver Manual, Part 6: http://www.in.gov/fssa/ddrs/4312.htm.

What are the different definitions of Algo levels?

0 Low

High level of independence (Few Supports needed). No significant behavioral issues. Requires minimal Residential Habilitation Services.

1 Basic

Moderately high level of independence (Limited supports needed). Behavioral needs, if any, can be met with medication or informal direction by caregivers (through the use of Medicaid state plan services). Although there is likely a need for day programming and light Residential Habilitation Services to assist with certain tasks, the client can be unsupervised for much of the day and night.

2 Regular

Moderate level of independence (Frequent supports needed). Behavioral needs, if any, met through medication and/or light therapy (every one to two weeks). Does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day.

3 Moderate

Requires access to full-time supervision (24/7 staff availability) for medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting

4 High

Requires access to full-time supervision (24/7 frequent and regular staff interaction, require line of sight) for medical and/or behavioral needs. Needs are moderately intense, but can still generally be provided in a shared setting.

5 Intensive

Requires access to full-time supervision (24/7 absolute line of sight support). Needs are intense and require the full attention of a caregiver (1:1 staff to individual ratio). Typically, this level of services is generally only needed by those with intense behaviors (not medical needs alone).

6 High Intensive

Requires access to full-time supervision (24/7 more than 1:1). Needs are exceptional and for at least part of each day require more than one caregiver exclusively devoted to the client. There is imminent risk of individual harming self and/or others without vigilant supervision.

Further information can be found in the 2012 DDRS Waiver Manual, Part 6: http://www.in.gov/fssa/ddrs/4312.htm.

How do you find the health Algo score on the ICAP tool?
The Health and Behavior Scores are found on the ICAP Addendum not the ICAP itself.

Can the Algo score be appealed if the individual or family disagrees with the score?
Yes. Also access the DDRS Waiver Manual 2012 Part 8 Appeal Process at http://www.in.gov/fssa/files/DDRS_Waiver_Manual_Fall_2012.pdf.

Is an ICAP or an Algo level given on the FSW?
No, due to the FSW having a capped amount of $16,250, an ICAP is not completed, thus, an Algo level is not assigned.

Does the FSW cover OT, Speech, etc.?
For a listing of available services on the Family Supports Waiver, please refer to the handout "Family Support Waiver (FSW) and Community Integration and Habilitation (CIH)," which is also found at http://www.in.gov/fssa/ddrs/3355.htm#Powerful_Parents.

HOUSEMATES/BUDGETS

What happens if an individual is unable to find suitable housemates to live with a two or more person budget?

Only individuals designated by the State as inappropriate for shared staffing or housemates will receive a "Living Alone" budget. All others will receive the base allocation of "Living with Two Housemates."

An individual may choose to live alone with the "Living with Two Housemates" budget or look at other waiver approved housing models that include Structured Family Caregiving or the addition of shared staff housemates. Individuals will receive up to six months to transition using the BMR process.

Is there a chart that illustrates the different budgets available to individuals, whether they live with family, alone, or with housemates?

	ALGO Level					
Individual RHS Daily Hours	**0**	**1**	**2**	**3**	**4**	**5 & 6**
	Low	**Basic**	**Regular**	**Moderate**	**High**	**Intensive & High Intensive**
Living with Family	0.2	2	3	5	7	8
Living Alone	0.2	2.6	6	9	11.7	21
Living with One Housemate	0.2	2.6	5.3	7.8	11	12
Living with Two Housemates	0.2	2.6	4.6	7.8	10.1	11
Living with Three Housemates	0.2	2.4	4.3	7.3	9.4	10
BMAN Reserve (Annual hrs)	0	0	36	72	108	144
Structured Family Caregiving ($/day)	51.87	51.87	75.87	102.87	102.87	102.87
Day Service Reserve ($/Yr)						
Not Attending School	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 18,000.00
Attending School or under 19yrs.	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00

There are families with disabled children in the current DD Waiver program that, due to medical reasons (for instance mental illness & acute behavioral issues), cannot have a housemate. For such a client with an Algo Level of 4 and residential staff assistance eight hours for each 24 hour period of time what, if any changes, are proposed under the successor CIH Waiver budget for a "Living Alone" disabled individual?
Only individuals designated by the State as inappropriate for shared staffing or housemates will receive a "Living Alone" budget. All others wishing to live alone will receive the base allocation of "Living with Two Housemates."

An individual may choose to live alone with the "Living with Two Housemates" budget or look at other waiver approved housing models that include Structured Family Living or the addition of shared staff housemates. Individuals will receive up to six months to transition using the BMR process.

Can an individual and his/her two housemates still be able to live in the community if they all have the FSW with its current capped budget?
The Family Supports Waiver is intended to be used by individuals who continue to live in the family home. If an individual can live within the structure of an FSW budget, he/she is welcome to live with housemates.

*Note that the FSW does **not** use the OBA methodology.*

Only individuals on the CIH waiver and designated by the State as inappropriate for shared staffing or housemates will receive a "Living Alone" budget. All others will receive the base allocation of "Living with Two Housemates."

On Sept.1, 2012, the FSW's cap went from $13,500 to $16,250. Since we received the waiver right before Sept. 1, do we get the $16,250?
Anyone who received a Support Services Waiver prior to September 1, 2012, was automatically transitioned to the Family Support Waiver on September 1, 2012, and a budget of up to $16,250 is available. However, individuals should only use the amount needed to provide services as developed by his/her Individualized Support Team.

Once on the waiver, the allocated amount is "per person," correct? (I have more than one child.)*Yes, each person gets their own allotment based on the needs as established by their Individualized Support Team.*

Home health is asking how many hours are allocated for home health services on the NOA, and if there is a gap, why?
Home health is NOT a service provided by the FSW or CIH waivers. Home health hours are determined through the ordering physician and your Medicaid plan; therefore, they will not

appear on the NOA. The NOA is for waiver funded services only. The home health agency is required to develop a plan of care and should know the hours they are authorized under Medicaid State Plan. More information about your Medicaid Plan can be found at http://member.indianamedicaid.com/ or by contacting member services at 1-800-457-7584.

FSW and CIH waiver services should be built around the services offered by Medicaid State Plan. Waiver services are not designed to be all inclusive. There is an expectation that natural or community resources are also explored.

MEDICAID/ASSETS

Can someone use M.E.D. Works and still be on a Medicaid Waiver?
M.E.D. WORKS is a permissible category for HCBS waivers. Individuals using this program would fall under the Medicaid Disabled Worker (MA DW) Medicaid category, which is a permissible Medicaid category for individuals seeking DDRS waiver services."

For more information about M.E.D. Works, please see Section 3.5: M.E.D. Works of the DDRS Waiver Manual at http://www.in.gov/fssa/ddrs/4312.htm.

What are the income asset limitations for Medicaid?
Section 1619b of the Social Security Act allows individuals who are eligible for Supplemental Security Income (SSI) to continue to be eligible for Medicaid coverage when their earnings are too high to continue to receive SSI. This work incentive applies to individuals whose earnings are below Indiana's threshold (currently $32,615 in 2009).

How it Helps You: If you are eligible for SSI and are employed, 1619b allows you to work and to keep Medicaid coverage without a Medicaid spend-down. You can continue to be eligible for Medicaid coverage until your gross annual income reaches a certain amount (this amount is $32,615 in 2009 if you are living in Indiana).

Exceptions to this work incentive are if you no longer need Medicaid, or if you accumulate more than $1,500 in resources (this is Indiana's Medicaid resource limit).

TRANSPORTATION

Can transportation be used for the following?

a. **community hab (nights and weekends also),**
b. **group hab**
c. **CHIO**
   OR
d. **only day services, res hab, and facilities hab?**

Waiver funded Transportation services may be used for any non-medical community based activity agreed upon as a need by the Individualized Support Team, outlined within the Individualized Support Plan, appearing on an approved CCB and reflected on a Notice of Action.

How much do providers reimburse if someone is using his/her personal vehicle to transport consumers? (regarding new transportation tiered rates)
Providers' terms with their staff are independent of policies established by the Division of Disability and Rehabilitative Services. Please contact your provider for specific information.

For the tiered transportation rates, the policy mentions rate "per trip." Is a trip defined as roundtrip, as in A->B->A, or per ride, as in A->B only?
The federally approved Community Integration and Habilitation Waiver is posted on the BDDS webpage at http://www.in.gov/fssa/ddrs/2639.htm. Transportation is reimbursable for up to two one-way trips per day as described on pages 153-155.

The listing of services under FSW includes transportation as its own service; is that really the case?
Transportation has long been a stand-alone service available under the FSW, and not combined with any other service. Residential Habilitation and Support is not an available service under the Family Supports Waiver (FSW). The FSW is posted on the BDDS webpage at http://www.in.gov/fssa/ddrs/2639.htm with the list of available services begins on page 58 of 208.

On FSW…can it be used for employment? My daughter secured a job but didn't qualify for our local bus door-to-door. She could sit with day services and get transportation (seems a little backward to me).
Refer to the currently approved FSW posted on the BDDS webpage at http://www.in.gov/fssa/ddrs/2639.htm, Transportation is available to enable waiver participants to gain access to non-medical community services and resources, which would include rides needed to and from her job.

Further, Transportation must be agreed upon as a need by the Individualized Support Team, outlined within the Individualized Support Plan, appearing on an approved CCB and reflected on a Notice of Action.

In our city, I can ride the bus through the Mets bus line for $2 a trip, but it costs my child $5 to go to work through transportation services through her DDRS Medicaid Waiver (FSW). Why the difference in cost?

The transportation rate on the family supports waiver is $5.00 per trip. According to CMS, the rate has to be consistent throughout the entire state of Indiana. While your area may be able to provide transportation for less than $5, other areas around the state are unable to do this.

On the CIH Waiver, can a different provider deliver transportation services if the RHS provider does not offer transportation as a service?

Yes, please request a transportation pick list from your case manager.

FAMILY AS PAID CAREGIVER

Can the parents of Algo 5 or Algo 6 individuals who are granted a Live-Alone budget provide 40 hours of direct care to their children?

Yes, as long as they meet the required criteria: Parents, step-parents and legal guardians of waiver participants who are minors (under the age of 18) may not receive payment for the delivery of any waiver funded service to the minor waiver participant(s). Per Section 4442.3.B.1 of the State Medicaid Manual, the Version 3.5 Instructions, Technical Guide and Review Criteria and the Code of Federal Regulations [42 CFR §440.167], all of which are published by the Center for Medicare and Medicaid (CMS), this prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide.

Other relatives (excluding spouses) may provide waiver service(s) to adult waiver participants when that relative is employed by or a contractor of a Division of Disability and Rehabilitative Services (DDRS)-approved provider.*

** For all purposes pertaining to waiver funded programs operated by DDRS, "related/relative" implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:*

1) Aunt (natural, step, adopted)
2) Brother (natural, step, half, adopted, in-law)
3) Child (natural, step, adopted)
4) First cousin (natural, step, adopted)
5) Grandchild (natural, step, adopted)
6) Grandparent (natural, step, adopted)
7) Nephew (natural, step, adopted)
8) Niece (natural, step, adopted)
9) Parent (natural, step, adopted, in-law)
10) Sister (natural, step, half, adopted, in-law)
11) Spouse (husband or wife)
12) Uncle (natural, step, adopted)

All of the following must be met before a relative may be considered to be a provider:

- *The individual receiving services is at least 18 years of age;*
- *The relative is employed by or a contractor of an agency that is approved by DDRS to provide care under the waiver:*

- *The relative meets the appropriate provider standards (per 460 IAC 6) for the service(s) being provided;*

- *The decision for the relative to provide services to an adult waiver participant is part of the Person Centered Planning process, which indicates that the relative* is the best choice of persons to provide services from the DDRS-approved provider agency, and this decision is recorded and explained in the Individualized Support Plan (ISP);*

- *There is detailed justification as to why the relative is providing service;*

- *The decision for a relative to provide service(s) is evaluated periodically (i.e. at least annually) to determine if it continues to be in the best interest of the individual;*
- *Payment is made only to the DDRS-approved provider agency in return for specific services rendered; and*

- *The services must be rendered one-on-one with the participant or in shared settings with group sizes allowable per specified waiver service definitions and documented as acceptable by all relevant individualized support teams. Authorization for shared or group services must be reflected on and documented via the approved Notice of Action for each group participant. With the exception of groups of waiver participants as noted above, the relative* may not be responsible for others (including their other children or family members) nor engaged in other activities while providing services.*

Under *Section 7.9: Parents, Guardians & Relatives Providing Waiver Services* of the 2012 DDRS Waiver Manual, is it now the case that families can only provide a total of 40 hours of paid caregiver supports (RHS, CHIO, etc) per individual, or can they provide 40 hours of RHS, 40 hours of CHIO, etc?
RHS is the only service that is capped. Therefore, theoretically, an individual could receive 40 hours of RHS and 40 hours of CHIO. We are updating the waiver manual due to the confusion caused by the statement, "The weekly total of reimbursable waiver funded services furnished to a waiver participant by any combination of relative(s) and/or legal guardian(s) may not exceed 40 hours per week."*

Can one family member bill 40 hours of RHS hours to an individual, while another family member bills for 40 hours for CHIO?
Yes, please see above.

Why can't family members be paid caregivers for RHS3 services?
At this time, we are still working with CMS to approve RHS3. The details will be released after RHS3 is approved by CMS.

PROVIDER QUALITY REIMBURSEMENT

One of the metrics by which providers are planned to be measured regarding quality reimbursement is the number of individuals they can get into integrated employment settings making over $2,500 per year. How does this affect an individual's asset limitations as it relates to his/her Medicaid status – which affects Waiver?

We feel that the goal of integrated employment and making over $2,500/year will not create an asset limitation as it relates to the person's Medicaid status. Like anyone else earning an income, we assume that a normal percentage will spent on expenses, food, school, entertainment, etc., thus enriching the consumer's quality of life.

http://www.iidc.indiana.edu/disabilitybenefitsandwork/medicaidsection1619b.htm

Section 1619b of the Social Security Act allows individuals who are eligible for Supplemental Security Income (SSI) to continue to be eligible for Medicaid coverage when their earnings are too high to continue to receive SSI. This work incentive applies to individuals whose earnings are below Indiana's threshold (currently $32,615 in 2009).

How it Helps You: If you are eligible for SSI and are employed, 1619b allows you to work and to keep Medicaid coverage without a Medicaid spend-down. You can continue to be eligible for Medicaid coverage until your gross annual income reaches a certain amount (this amount is $32,615 in 2009 if you are living in Indiana).Exceptions to this work incentive are if you no longer need Medicaid, or if you accumulate more than $1,500 in resources (this is Indiana's Medicaid resource limit).